Is the DNP Fulfilling its Promise?

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Given the rapid expansion of Doctor of Nursing Practice (DNP) programs and the sudden increase in the number of DNP programs and graduates enrolled in these programs, it is natural that there is wide interest in this new practice degree. A phenomenon in its own right, it has eclipsed discussions and collegial sharing around the PhD and other research-focused doctoral programs. The following quotes are from the American Association of Colleges of Nursing (AACN, 2013) on the inception and intent of the DNP:

“On October 25, 2004, the member schools affiliated with the American Association of Colleges of Nursing (AACN) voted to endorse the Position Statement on the Practice Doctorate in Nursing. This decision called for moving the current level of preparation necessary for advanced nursing practice from the master’s degree to the doctorate-level by the year 2015. This endorsement was preceded by almost three years of research and consensus-building by an AACN task force charged with examining the need for the practice doctorate with a variety of stakeholder groups.

“The DNP is designed for nurses seeking a terminal degree in nursing practice and offers an alternative to research-focused doctoral programs. DNP-prepared nurses are well-equipped to fully implement the science developed by nurse researchers prepared in PhD, DNSc, and other research-focused nursing doctorates.”

AACN (2013) further reports that in 2012, there were 184 DNP programs, with 101 additional programs in the planning stages. At the same point, there were 125 PhD and other research-focused doctoral programs in place. At an AACN PhD summit in September 2013, updates were provided as follows (for the 2012-2013 academic year): 131 PhD programs, with 4,452 enrolled students and 531 graduates. In contrast, there were 217 DNP programs, with 10,545 enrolled students and 1,715 graduates. It is worth noting that PhD and research-focused doctorates developed over a period of 80 years (1932-1933 to the present, Teachers College Columbia University was the first, followed by New York University, both offering the EdD). The exponential growth in DNP programs, their students, and graduates can be seen from the above figures.

Additional Facts and Commentary
1. Many institutions are opening DNP programs in order to use such graduates to fill the vacancies created by retiring faculty, despite the fact that faculty roles were not the intended positions for graduates of this program.
2. When advanced practice preparation moves to the DNP level (from the master’s) in a few years, and many graduates continue to take faculty positions, we will be depriving the nursing practice environments and patients of individuals who have clinical expertise, the very purpose for which the DNP was created.
3. The above information from the AACN says that graduates of this degree are equipped to implement the science developed by nurse researchers. Despite this claim, when DNP curriculums are examined, one finds that the research component is meager, with one course in research, and some also including a course and practicum on evidence-based practice; the largest number of schools offer a course on quality improvement (QI). (It needs to be acknowledged that there may be exceptions and variations to these curricular patterns as far as the research component.

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and other elements in DNP programs. Minnick, Norman, and Donaghey (2012) surveyed DNP programs on capacity issues, and reported the various curricular elements on scholarship that are included; these are meager and do not seem sufficient or of a nature to enable graduates to implement, apply, or translate the available science into patient care. To be able to function in the specified manner, graduates need to have had relevant coursework and experiences to be able to evaluate, synthesize, and translate research; content not in the DNP curriculums at present.

4. Schools are claiming that graduates of DNP programs are hired on clinical tracks, not the regular tenure track. However, these faculty are assigned responsibility for teaching courses and overseeing junior faculty or graduate student teaching assistants. While a few (five in the study by Minnick et al., 2012) schools do include modest content on curriculum and teaching, many do not. Minimal content conveyed in one course, or no content at all, do not prepare graduates to function as teachers/educators. In any case, this is not why the DNP was created as a degree, although holders of the degree are said to “be prepared to provide clinical teaching support” (Minnick et al., 2012, p. 93).

5. Some institutions are now attempting to recruit new baccalaureate graduates into their DNP programs. This means that these individuals will have had only a minimal amount of practice experience; they will obtain some supervised practice experience with advanced practice nursing courses during their program of study. Upon graduation, this type of graduate cannot be considered to be an expert in nursing practice, although those hiring them will expect expert practice performance.

6. Minnick et al. (2012) reported significant PhD prepared and research-active faculty engagement in various teaching activities for DNP students (in settings where both degrees are offered, as well as those offering only the DNP). This raises concerns about faculty work overload and whether institutions added to their faculty contingent commensurate with DNP program needs when they initiated the new degree, or whether the DNP program was added with the expectation that existing faculty would manage it. The extent to which the latter solution was sought, it can jeopardize faculty research, the attention faculty members are able to devote to their PhD students’ academic and scholarly development, and indeed to the entire nursing research enterprise.

7. Minnick and colleagues (2012) documented that those entering DNP study following a master’s degree receive minimal, if any, further clinically-oriented content, and those entering DNP study after a bachelor degree receive clinical courses early in the curriculum, but the extent to which they are similar or equivalent to clinical content in master’s programs was not known.

8. Minnick et al. (2012) noted a large number of DNP programs reporting that students can complete requirements without having to reside in the area, and their use of various combinations of program delivery strategies. Those might lead one to wonder whether these approaches are employed for their educational benefits or for any expected benefits, such as more efficient use of faculty resources.

Many international colleagues are now discussing the idea of whether the DNP is right for them. In many instances, these countries do not have a strong foundation of advanced practice to build on. As they consult various of us from the U.S., it has become evident (anecdotally) that the nature of the advice they receive depends on the consulted person’s bias—pro or con—regarding the DNP rather than the specific situation in a given country.

There are many unanswered questions and concerns that the current situation raises in view of the course that the DNP education has taken since its inception. Some of these are: Is the degree fulfilling its mission? What impact is it having on existing structures such as the PhD program and the production of nursing science? What impact is it having on master’s programs and the preparation of clinical nurse specialists (CNSs) and nurse practitioners (NPs)? Is there any dissatisfaction with the current preparation for CNSs and NPs that requires a new degree? What impact is it having on practice environments? If a new role or degree is indeed needed in nursing, does the current format and content of the DNP provide/fulfill the right combination to respond to the need? Is there a good fit or a disconnect between what is needed for nursing practice and what the DNP actually offers at present? What kinds of studies are needed by the practice sector, and what type of preparation is required to conduct them? How do patient outcomes compare when care is provided by CNSs and NPs versus when care is provided by DNP graduates? What value is being added to nursing practice by the DNP student projects, especially with the emphasis being placed on QI? What are faculty and other resource needs to conduct a high quality DNP program? What are pros and cons of combining students from the PhD and DNP programs together in courses and other activities, in terms of student development, their satisfaction, and their socialization?

Answers to the above questions might provide informed guidance for the next decade of these programs. I welcome your comments and feedback.

References
The National Council of State Boards of Nursing (NCSBN) launches new online course

“Understanding the NCLEX — A Guide for Nursing Educators”

The National Council of State Boards of Nursing (NCSBN) launched a new online course, “Understanding the NCLEX—A Guide for Nursing Educators.” This course joins an innovative catalogue of courses for nursing students, faculty, and nursing professionals, offered by NCSBN’s Learning Extension online campus.

Written by NCSBN NCEX Examinations department staff, this course helps educators understand testing history, process, and methodology. Armed with this knowledge, educators will be better equipped to help calm fears and set the facts straight for their students.

Designed to accommodate the needs of busy nurse educators, the course is provided in a flexible e-learning format allowing for three weeks of unlimited 24-hour access for only $30. As educators work through the course at their own pace, they can complete an interactive workbook that provides helpful links and a ‘cheat sheet’ that can be used to coach students. Also provided are nursing instructor materials, including NCLEX Internet resources, a built-in glossary, and an online notepad. At the completion of the course, educators can synthesize knowledge through an “Understanding the NCLEX—A Guide for Nursing Educators” Posttest. Those who score 75% or above on the Posttest receive 3.0 contact hours for the course.

To enroll or for more information, visit the NCSBN Learning Extension at http://learningext.com/faculty/p/understanding_nclex.aspx.

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Speakers: Mary Cato, EdD, RN, Assistant Professor, Oregon Health and Science University, Portland, OR; Barbara McLaughlin, DNSC, RN, Professor and Head, Department of Nursing, Community College of Philadelphia; Cynthia Reese, PhD, RN, CN, Associate Dean of Nursing, Lincoln Land Community College, Springfield, IL; Laureen Travolaro-Ryley, MSN, RN, Gero-Psychiatric Clinical Nurse Specialist, Associate Professor of Nursing, Community College of Philadelphia; M. Elaine Tagliareni, PhD, RN, FAAN, Chief Program Officer, National League for Nursing, New York

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*A total of 14 contact hours will be awarded for this program by the National League for Nursing, an approved provider through the International Association of Continuing Education and Training.
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Program Highlights

Keynote Speaker: Gloria Ferraro Donnelly, PhD, RN, FAAN, Dean of the College of Nursing and Health Professions, Drexel University, Philadelphia, PA

Endnote Speaker: Virginia Trotter Betts, MSN, JD, RN, FAAN, Professor, Department of Advanced Practice and Doctoral Studies, College of Nursing, University of Tennessee Health Science Center, Memphis, TN, and former Commissioner of the (Tennessee) Department of Mental Health and Developmental Disabilities

General Session – Interdisciplinary Collaboration: Elizabeth Speakman, EdD, RN, CDE, ANEF Associate Professor, Associate Dean of Student Affairs, Thomas Jefferson School of Nursing, Philadelphia, PA

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